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June 24, 2010

Heather Davis
Home Again ICF
2311 Aruba Drive
Nampa, ID 83686

Provider #13G078

Dear Ms. Davis:

On **June 22, 2010**, a complaint survey was conducted at Home Again ICF. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004656

Allegation #1: Individuals are not receiving their medications as scheduled, and medications are passed by non-certified staff.

Findings #1: An unannounced onsite complaint investigation was conducted on 6/21/10 and 6/22/10. During that time, observations, record review, review of personnel records, and staff interviews were conducted with the following results:

Observations were conducted during the course of the survey for a cumulative 5 hours and 40 minutes. During that time, individuals were observed to participate in taking their medications. All individuals were noted to received their medications as per their physician's orders.

Additionally, eight individuals' Medication Administration Records (MARs) were reviewed and showed all scheduled medications were received by individuals in accordance with their physician's orders.

Further, staff signatures on eight individuals' MARs were compared with personnel records. Personnel records showed all staff assisting individuals with medications were certified to do so.

Seventeen direct care staff were interviewed during the course of the survey. All staff stated if they were not certified in medication administration, they were not allowed to assist individuals with their medications.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: There is a lack of sufficient nursing oversight and follow-through with individuals' medical concerns.

Findings #2: An unannounced onsite complaint investigation was conducted on 6/21/10 and 6/22/10. During that time, observations, record review, and individual and staff interviews were conducted with the following results:

During the entrance conference, the Administrator reported an investigation was conducted regarding the performance of the facility's previous nurse. That investigation showed the facility's previous nurse received both verbal and written counseling regarding failure to follow through with medical appointments, failure to ensure appointments were scheduled in a timely manner, failure to ensure medications were delivered to the facility in a timely manner, and failure to provide adequate and appropriate documentation. The investigation showed the nurse failed to respond to the identified concerns and was released from employment on 5/30/10. The Administrator reported a new nurse was hired and started 6/21/10. The Administrator reported the facility's Registered Nurse (RN) provided increased oversight between 5/30/10 and 6/21/10.

Eight individuals medical records were reviewed and documented all identified health concerns had been addressed. The records contained evidence of sufficient nursing oversight from the RN. Further, all eight records contained evidence the appointments missed by the previous nurse had either been completed or had been scheduled for completion.

Observations were conducted during the course of the survey for a cumulative 5 hours and 40 minutes. During that time, six individuals agreed to be interviewed regarding their health and the facility's response to their medical concerns. All six individuals stated they had no health concerns and stated they were satisfied with the medical treatment they received.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Restrictive interventions are implemented without appropriate consents in place.

Findings #3: An unannounced onsite complaint investigation was conducted on 6/21/10 and 6/22/10. During that time, record review and staff interviews were conducted with the following results:

Eight individuals' records were reviewed and documented written informed consents were present for all individuals' restrictive interventions. The consents were signed by individuals' guardians and the facility's Human Rights Committee. Additionally, all consents were noted to contained accurate information.

During the course of the survey, the Administrator was interviewed and stated all consents had been reviewed and revised as needed based upon the facility's Recertification Survey, dated 4/23/10.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Individuals engage in sexually self-stimulating behavior without plans in place to address it.

Findings #4: An unannounced onsite complaint investigation was conducted on 6/21/10 and 6/22/10. During that time, observations, record review, and staff interviews were conducted with the following results:

Observations were conducted at the facility for a cumulative 5 hours and 40 minutes. During that time, no individuals were noted to engage in sexually self-stimulating behavior.

Eight individuals' assessments and training plans were reviewed. No identified concerns with sexually self-stimulating behavior were noted to be present within those documents. One individual's record contained documentation from the psychiatrist that stated the individual occasionally engaged in sexually self-stimulating behavior. However, no concerns or recommendations were noted regarding the behavior.

During the course of the survey, a senior staff was asked about individuals' sexually self-stimulating behavior. The staff reported there were no identified concerns with individuals' sexually self-stimulating behavior that would warrant training plans.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Staff are not utilizing appropriate safety measure during transportation of individuals.

Findings #5: An unannounced onsite complaint investigation was conducted on 6/21/10 and 6/22/10. During that time, observations and individual and staff interviews were conducted with the following results:

Observations were conducted for a cumulative 5 hours and 40 minutes. During that time, individuals and their staff were observed to leave the facility in the facility's van. It was noted the facility's van had the capacity to seat twelve people. No more than 9 people (individuals and staff combined) were noted to be in the van at one time. All individuals and all staff were noted to be wearing seatbelts while in the van.

Additionally, 17 direct care staff were interviewed during the course of the survey. All staff stated everyone had to wear seatbelts while in the van. One staff stated an incident occurred during the past month where 13 people were in the van. As a result, a staff member sat on the floor of the van without a seatbelt. The staff stated the incident was reported to charge staff and all staff were re-trained on proper van safety procedures. Staff were instructed to take their own vehicle if there were not enough seats on the van. The staff stated no further incidents had occurred.

Further, one individual residing at the facility was interviewed and confirmed the incident where a staff member sat on the floor of the van without a seatbelt. The individual stated no further incidents had occurred.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srp